COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

CHART Phase 2: Implementation Plan Milford Regional Medical Center

HPC approval date: August 31, 2015

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Version: 3

Introduction

This Implementation Plan details the scope and budget for Milford Regional Medical Center's ("Contractor") Award in Phase 2 of the Health Policy Commission's (HPC) Community Hospital Acceleration, Revitalization, and Transformation (CHART) Investment Program. The Implementation Plan is incorporated by reference into and is subject to the requirements of the Phase 2 Award Contract, including the Phase 2 Terms & Conditions.

Many capitalized terms appearing in the Implementation Plan are defined in the Phase 2 Terms & Conditions or the Phase 2 Request for Proposals (RFP). In addition to capitalized terms, the Implementation Plan may include other acronyms and/or abbreviations whose meaning is understood by Contractor and the HPC in the context of the Implementation Plan. If there is disagreement concerning the meaning of a term, acronym, or abbreviation, the HPC's interpretation shall govern.

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Key personnel

Name	Title	CHART Phase 2 Role
Edward Kelly	President and CEO	Executive Sponsor
Judy Kelly	Vice President Patient Care Services and Chief Nursing Officer	Clinical Investment Director
Peggy Novick	Vice President Clinical and Support Services	Operational Investment Director
Annette Roberts	Director of Performance Improvement and Quality	Project Manager
Kim Robinson	Manager Reimbursement and Budget	Financial Designee

Target population

Definition:

- Patients with ≥3 hospitalizations in the past 12 months*

Quantification:

- 1,248 discharges per year; 352 distinct patients

*Target population definition includes all payers and aged 18+; excluding OB, deaths, transfers to acute inpatient, and discharge to acute rehab

Aim Statement

Primary Aim Statement

Reduce 30-day readmissions by 25% for patients with ≥3 inpatient discharges in the last year by the end of the 24 month Measurement Period.

Secondary Aim Statement*

Reduce 30-day ED revisits by 10% for patients with ≥3 inpatient discharges in the last year by the end of the 24 month Measurement Period.

*Your secondary Aim Statement is a performance measure only and is not tied to Achievement Payment.

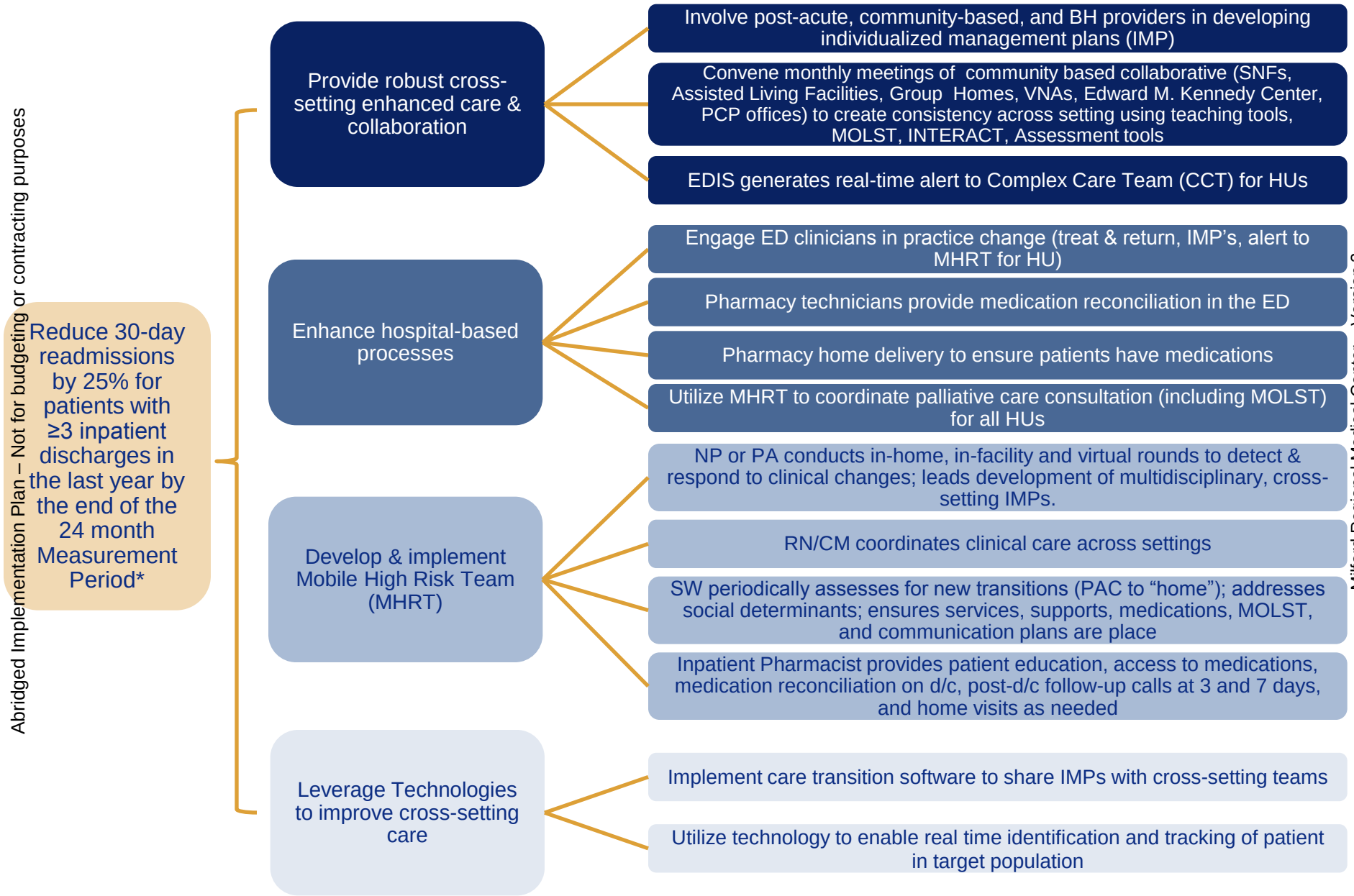
Baseline performance – Readmission reduction

		Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Avg.
Hospital-Wide	Readmits	60	42	74	68	69	68	83	53	54	56	49	64	62
	Discharges	520	389	486	513	485	484	512	457	450	491	453	530	481
	Rate (%)	11.5 %	10.8 %	15.2 %	13.3 %	14.2 %	14.0 %	16.2 %	11.6%	12.0 %	11.4 %	10.8 %	12.1 %	12.8 %
Target Pop	Readmits	31	26	48	39	42	44	60	38	39	34	35	25	38
	Discharges	90	84	117	123	104	110	134	116	97	85	92	99	104
	Rate (%)	34.4 %	31.0 %	41.0 %	31.7 %	40.4 %	40.0 %	44.8 %	32.8%	40.2 %	40.0 %	38.0 %	25.3 %	36.5 %

Estimated monthly impact

	Current Expected Served	Current Expected Readmissions	New Expected Avoided Events	New Expected Events
30-day readmission reduction	104 discharges served per month in the target population	38 readmissions per month, at a current rate of 36.5%	With a goal of 25% readmission reduction, we expect 10 avoided readmissions per month	Then, we expect 28 readmissions per month

Driver Diagram – Readmissions



*High utilizers are defined as three or more discharges in the past 12 months. Target population definition includes all payers and aged 18+; excluding OB, deaths, transfers to acute inpatient, and discharge to acute rehab

Service model

Narrative description

Our target population (high utilizers), will be identified and flagged in the emergency department (ED) upon entry and patient's individualized management plan (IMP), if present, will be accessed. Mobile High Risk Team (MHRT) will be paged to support ED assessment, assessment for palliative care services, facilitation to admission alternative if clinically appropriate, and creation/update of IMP. Pharmacy technician will conduct medication reconciliation in the ED.

Our ED physician champion has developed a treat and return pilot program with the medical director from one of our community SNFs. Those patients' medical needs will be assessed, treated, and status for return versus admission will be communicated with the SNF medical director. Patients in target population being admitted to inpatient status will have their medications optimized by the pharmacist.

Implementation of a concierge pharmacy delivery to provide patients a 30-day supply of medications upon discharge. Inpatient pharmacist conducts post-hospital follow-up calls and/or home visit for HUs.

Patients at high risk for readmission will be seen and followed by our MHRT, with the focus on those identified high utilizers. The team will meet the patient on admission and begin planning the transition to home or other services. The MHRT will participate in multidisciplinary complex care rounds and will identify needs regarding medications, palliative care, psychosocial, physical therapy, occupational therapy, nursing care. Upon discharge, 1-2 clinicians from the MHRT team will visit the patient within 48 hours and conduct an in-home assessment of social supports needs. If the patient is discharged to SNF/rehab, they will also follow the patient there to prepare for his/her transition home.

After the initial home visit, the team will identify the most appropriate team members for continued follow-up. The timing of future visits or post- discharge telephone calls will be determined by the initial assessment. The patients/families will have contact information to reach the team. This team will follow the patient for 30 days post discharge.

Service worksheet

Service Delivered

- Care transition coaching x
- Case finding x
- Behavioral health counseling x
- Engagement x
- Follow up x
- In home supports x
- Home safety evaluation
- Logistical needs x
- Whole person needs assessment x
- Medication review, reconciliation, & delivery x
- Education x
- Advocacy x
- Navigating x
- Peer support
- Crisis intervention x
- Motivational interviewing x
- Linkage to community services x
- Physician follow up x
- Adult Day Health
- Other: _____
- Other: _____
- Other: _____
- Other: _____
- Other: _____

Personnel Type

- Hospital-based nurse x
- Hospital-based social worker x
- Hospital-based pharmacist x
- Hospital-based NP/PA/APRN x
- Hospital-based behavioral health worker
- Hospital based psychiatrist
- Community-based nurse
- Community-based social worker
- Community-based pharmacist
- Community-based behavioral health worker
- Community-based psychiatrist
- Community-based advocate
- Community-based coach
- Community-based peer
- Community agency
- Physician
- Palliative care x
- EMS
- Skilled nursing facility
- Home health agency
- Other: _____
- Other: _____
- Other: _____
- Other: _____
- Other: _____

Service Availability

- Mon. – Fri. x
- Weekends x
- 7days x
- Holidays X
- Days x
- Evenings
- Nights
- Off-Shift

Hours __x__

Case management covers the ED until 10pm. Case Manager will access IMP and MHRT will be available for telephonic consultation if needed.

Service mix

Service	By Whom	How Often	For How Long
Navigating post-hospital care (MD appointments, services, etc.)	Mobile High Risk Team	As needed (1-10 encounters)	30 days – likely with HU will have caseload ongoing
Home visits/Coaching	Mobile High Risk Team	Will be determined after initial visit and assessment of needs	30 days
Pharmacy consult (in hospital, in-home or via telephone)	Pharmacist	As needed	30 days
Medication reconciliation	Pharmacy technician	ED	Ongoing
Transition visits to SNF	Mobile High Risk Team	After transfer to SNF, then as needed to prepare for d/c	30 days
Palliative care consultation	Coordinated by Mobile High Risk Team	As needed	Ongoing
Concierge Pharmacy	Business agreement with local pharmacy for same day med delivery	Each patient discharge to home (focused on the HU population)	30 days
# FTE/units of service hired at my organization		0.8 NP/PA, 1 LCSW, 1 Pharmacist, 0.6 Pharm tech, 1 RN CM	
# FTE/units of service contracted		0	

List of providers/community agencies

Type of Service Provider	Community Agency Name	New or Existing Relationship
VNA/Home Care	Care Tenders	Existing
VNA/Home Care	Medical Resources	Existing
VNA/Home Care	VNA Care Network	Existing
VNA/Home Care	Salmon VNA	Existing
VNA/Home Care	Walpole VNA	Existing
SNF	Beaumont-Northbridge (Pilot site for Treat & Return)	Existing
SNF	Blair House	Existing
SNF	Franklin Health & Rehab	Existing
SNF	Genesis Healthcare	Existing
SNF	Timothy Daniels	Existing
SNF	Thomas Upham	Existing
SNF	Lydia Taft	Existing
SNF	Medway Country Manor	Existing
PCP office	Tri River Medical Group	Existing
PCP office	Tri County Medical Group	Existing
PCP office	Reliant Medical Group	Existing
Behavioral Health ESP	Riverside Community Care	Existing

Summary of services

Narrative description of clinical service and staffing mix

0.8 NP/PA; 1.0 SW; 1.0 RN CM; 1.0 Pharmacist; 0.6 Pharm Tech

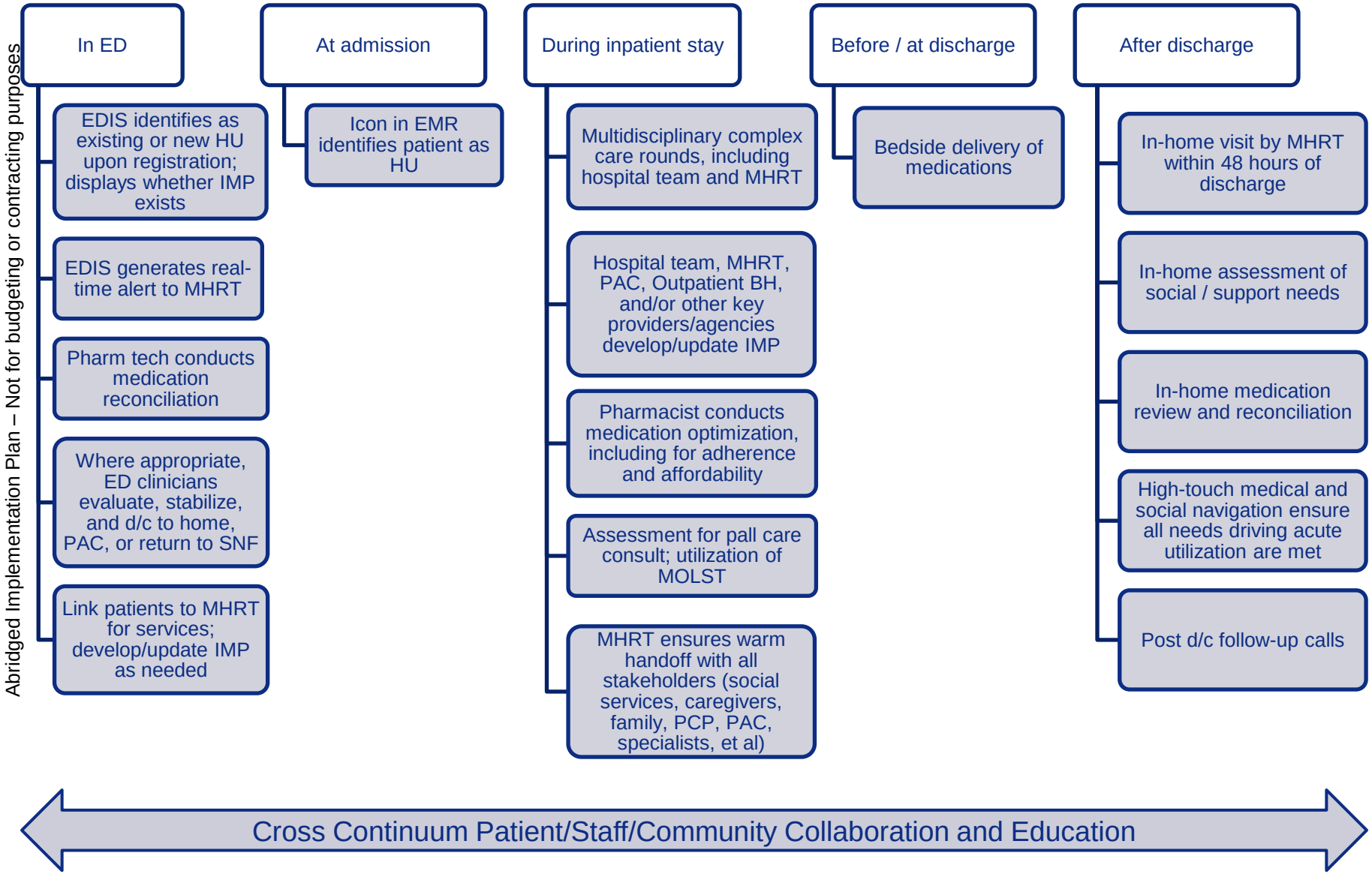
In ED
- ED Information System (EDIS) will identify HU upon registration
- When HU registers, EDIS will generate real-time alert to Mobile High Risk Team (MHRT)
- Utilization report will be produced for Program Manager and MHRT to review daily, weekly
- Icon in EDIS and inpatient EMR to identify if patient is existing/new HU and whether IMP exists
- Pharm Tech in ED to do medication reconciliation
- Practice change to support ED clinicians in process to evaluate, stabilize and d/c to care of MHRT or return to SNF when safe and appropriate

In Hospital
- Multidisciplinary complex care rounds including hospital team and MHRT
- Include PAC, outpatient BH, or other key providers/agencies in development of IMP
- Pharmacist conducts medication optimization, including for adherence, affordability
- 100% palliative care assessments for HU, as appropriate
- MOLST forms filled out for HU, as appropriate
- Bedside delivery of meds
- MHRT ensures warm communication with all relevant stakeholders (social services, caregivers, family, PCP, PAC, specialists, as needed)

Post-Hospital
- In-home post-hospital visits by MHRT <48h of discharge
- In-home assessment of social / support needs by MHRT
- In-home medication review and reconciliation by MHRT
- High-touch medical and social navigation by MHRT to ensure all needs that may drive acute utilization are met

Systems
- IT to flag, notify, share care plans, facilitate multi-agency/provider care coordination for complex individuals
- Cross-continuum team to specifically coordinate on HU care plans
- Cross-continuum team to align and strengthen joint specific improvement opportunities
- 100% Readmission review for all readmissions in target population

Summary of services – Services flowchart



Cohort-wide standard measures – Hospital utilization measures

Data elements	All	Target Population
1. Total Discharges from Inpatient Status (“IN”)	x	x
2. Total Discharges from Observation Status (“OBS”)	x	x
3. SUM: Total Discharges from IN or OBS (“ANY BED”)	x	x
4. Total Number of Unique Patients Discharged from “IN”	x	x
5. Total Number of Unique Patients Discharged from “OBS”	x	x
6. Total Number of Unique Patients Discharged from “ANY BED”	x	x
7. Total number of 30-day Readmissions (“IN” to “IN”)	x	x
8. Total number of 30-day Returns (“ANY BED” to “ANY BED”)	x	x
9. Total number of 30-day Returns to ED from “ANY BED”	x	x
10. Readmission rate ("IN readmissions" divided by "IN")	x	x
11. Return rate (ANY 30-day Returns divided by “ANY BED”)	x	x

Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

Note: Data elements that do not have a population selected are not required for measurement. Not all measures are required for all hospitals.

Cohort-wide standard measures – ED utilization measures

Data Elements	All	Target Population
12. Total number of ED visits	x	x
13. Total number of unique ED patients	x	x
14. Total number of ED visits, primary BH diagnosis	x	x
15. Total number of unique patients with primary BH diagnosis	x	x
16. Total number of ED visits, *any* BH diagnosis	x	x
17. Total number of unique patients with any BH diagnosis	x	x
18. Total number of 30-day ED revisits (ED to ED)	x	x
19. Total number of 30-day revisits (ED to ED), primary BH diagnosis		
20. Total number of 30-day revisits (ED to ED), any BH diagnosis		
21. ED revisit rate	x	x
22. ED BH revisit rate (primary BH diagnosis only)		
23. ED BH revisit rate (any BH diagnosis)		
24a. Median ED LOS (time from arrival to departure, in minutes)	x	x
24b. Min ED LOS (time from arrival to departure, in minutes)	x	x
24c. Max ED LOS (time from arrival to departure, in minutes)	x	x
25a.Median ED LOS (time from arrival to departure, in minutes), primary BH diagnosis		
25b. Min ED LOS (time from arrival to departure, in minutes), primary BH diagnosis		
25c. Max ED LOS (time from arrival to departure, in minutes), primary BH diagnosis		
26a. Median ED LOS for ED boarders per DPH boarder definition (patients with a primary behavioral health diagnosis who remain in the ED for 12 or more hours from ED arrival to ED departure)		
26b. Min ED LOS for ED boarders per DPH boarder definition (patients with a primary behavioral health diagnosis who remain in the ED for 12 or more hours from ED arrival to ED departure)		
26c. Max ED LOS for ED boarders per DPH boarder definition (patients with a primary behavioral health diagnosis who remain in the ED for 12 or more hours from ED arrival to ED departure)		

Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

Note: Data elements that do not have a population selected are not required for measurement. Not all measures are required for all hospitals.

Cohort-wide standard measures – Service delivery measures

Data elements	Target Population
27. Total number of unique patients in the target population	x
28. Number of acute encounters for target population patients	x
29. For acute encounters in measure #28, number of these with any CHART service provided after discharge and within 48 hours	x
30. Total number of contacts for the target population	x
31. Average number of contacts per patient served	x
32a. Min number of contacts for patients served	x
32b. Max number of contacts for patients served	x
33. Number of units of service provided by service modality (including, e.g., phone call, virtual interaction, face to face in office, face to face in home, etc.)	x
34. Number of units of service provided, by service types (e.g., care coordination, medication optimization, clinical care, counseling, needs assessment, etc.)	x
35. Number of units of service provided, by role type (NP/PA, LICSW, Pharmacist, Community Health Worker, Peer)	x
36. Average time (days, months) enrolled in CHART program per patient	x
37. Range time (days, months) enrolled in CHART program per patient	x
38. Proportion of target population patients with care plan	x

Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

Note: Data elements that do not have a population selected are not required for measurement. Not all measures are required for all hospitals.

Cohort-wide standard measures – Payer mix specific measures

Data elements	Medicare	Medicaid	Commercial
39. Count of patients in the Target Population	x	x	x

Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

Note: Data elements that do not have a population selected are not required for measurement. Not all measures are required for all hospitals.

Program-specific measures – High utilizer

Measure ID	Measure Description
H001	Number of TP patients identified for whom there is a full six months of time passed following CHART eligibility
H002	Total discharges for 6 months before CHART eligibility
H003	Total 30-day readmissions for 6 months before CHART eligibility
H004	Total ED visits for 6 months before CHART eligibility
H005	Total 30-day ED revisits for 6 months before CHART eligibility
H006	Total discharges for 6 months starting on and inclusive of the date of CHART eligibility
H007	Total 30-day readmissions for 6 months starting on and inclusive of the date of CHART eligibility
H008	Total ED visits for 6 months starting on and inclusive of the date of CHART eligibility
H009	Total 30-day ED revisits for 6 months starting on and inclusive of the date of CHART eligibility
H010	Total months following CHART eligibility without exit event

Program-specific measures

Updated Measure Definition	Numerator	Denominator	Based on your enabling technology decision, how will you collect this information?
Treat and return for target population	# of patients coming from SNF to ED who are returned to SNF w/o admission	# of patients coming from SNF to the ED	Pulsecheck
MOLST on file	# of patients in the denominator with MOLST on file	Patients in the target population, i.e. HU's	Meditech/ONBase
Palliative care consults refused	# of HU with Palliative refusal	# of High Utilizers	Manual
Palliative care consults- completed	# of HU who have Palliative care consult (as appropriate)	# of High Utilizers	Meditech
Total number of ED visit discharged to home	# of ED visits discharged to home	N/A	Pulsecheck

Continuous improvement plan (1 of 2)

1. How will the team share data? Describe.	The Investment Directors/Program Manager will share the target population readmission data with PI Committee, Department Managers, and Patient Care Assessment Committee on a quarterly basis. Data will also be shared daily during rounds.
2. How frequently will you (PM, Investment Director) look at the data (e.g., weekly)? Describe.	Daily/Weekly
3. How often will your executive team (VPs, C-suite) review CHART project reporting (e.g., monthly)? Describe.	This will be reported monthly to the Senior Management Team
4. How often will your front line CHART staff (SW, care team) review reporting (e.g., weekly)? Describe.	The MHRT will review daily and share reports with staff at rounds.
5. How often will your community partners review data (e.g., weekly, monthly)? Describe.	Data will be shared monthly at our community partners meetings.
6. Which community partners will look at CHART data (specific providers and agencies)? Describe.	SNFs, Home Care Agencies, PCP offices who have been engaged in our CHART Phase 1 and who continue to be invested in CHART Phase 2 in order to create a safe transition from the hospital, and also to reduce readmissions.
7. Will the quality committee of your board review CHART reporting (e.g., quarterly)? Describe.	Patient Care Assessment Committee on a quarterly basis.

Continuous improvement plan (2 of 2)

<table>
<tr><td rowspan="2">8. Who will collect measures and produce reporting for Cohort-wide and program specific measure (e.g., Data Analyst, PM, ID)? Describe.</td><td>Cohort-Wide</td><td>Program specific</td></tr>
<tr><td>Program Manager</td><td>Program Manager</td></tr>
<tr><td rowspan="2">9. What is your approximate level of effort to collect these metrics? Describe</td><td>Cohort-Wide</td><td>Program specific</td></tr>
<tr><td>Building some of these reports may require systematic changes to workflow and documentation.</td><td>MRMC currently has 1 programmer to respond to request for building reports.</td></tr>
<tr><td>10. How will you ensure that you are able to collect both your program specific and the cohort-wide measures? Describe.</td><td colspan="2">Work collaboratively with IT. Testing / validating reports that are developed.</td></tr>
<tr><td>11. How will you know when to make a change in your service model or operational tactics? Describe.</td><td colspan="2">Continual reassessment of our program on a daily/weekly basis will identify areas for improvement/change in service model. We will utilize the PDSA model for improvement. Because MRMC is a small, independent community hospital, it offers us the ability to be more nimble when implementing and testing changes. We will be able to know if our model / changes are successful based on the number of ED visit bounce backs and readmissions.</td></tr>
</table>

Enabling Technologies plan

Functionality	User	Vendor	Cost
Tools to facilitate transitions of care which include providing all pertinent information at time of discharge/transfer. Also will provide post discharge communication that can be viewed by MRMC, MHRT and community partners.	Case Managers, Social Workers, MHRT, SNFs, VNA/Home Care, PCP offices	All Scripts – Care Management suite	$234,000

Enabling Technologies plan – Q&A

- How are you going to identify target population patients in real-time?
  - Patients will be identified upon arrival in the ED via a flag that identifies patient as having an admission within the last 30 day
- How will you measure what services were delivered by what staff?
  - Allscripts Case Management Reports
- How will you measure outcome measures monthly?
  - Allscripts and Medisolv
- What tool/platform will you use to facilitate cross-setting and multi-disciplinary coordination of care?
  - Allscripts Case Management, Care Director
- Where will individual management plans reside, and what is the plan for making them available on a need-to-know basis 24/7 in the ED, hospital, and ambulatory settings?
  - Pulsecheck, Allscripts Case Mangement
- Do you have a method for identifying what clinical services your target population accesses?
  - Reliant Medical Group patients are seen in the Emergency Department, MEDITECH sends an electronic Admission HL7 message to their EMR notify them that a patient is seen in the ED. Soon this HL7 message will trigger a CCD to be sent to MRMC. For all other providers, a fax notification is sent by the system to the physician notifying them that one of their patients has been seen in the ED.

Other essential investments

Other Investments	Budget Required
Concierge Pharmacy Delivery Program: Family Pharmacy Inc. will provide medication delivery service. Our MHRT pharmacist will continue to educate and assist HU with medication management/access.	$5,590
Palliative Care Education/Training -MRMC recognizes the need for our staff, community partners, patients and families to gain knowledge regarding palliative care. We will look into options for development of training programs vs purchase of programs already developed for education and provide this training to MRMC staff, care partners in the community , and patients and their families.	$5,000
Quarterly SNF/Nursing home collaborative meeting	$5,000 (in-kind)
Travel budget for Mobile High Risk Team	$10,220
Tablets for use by Med Reconciliation Techs – can review meds with patient while reviewing prescription history	$1,100
4 smartphones and 2 laptops for the MHRT team	$6,130

Key dates and work plan

Key milestone	Date
Launch date (beginning of your 24 month Measurement Period)	10/1/15
Post jobs	7/10/15—7/30/15
New hires made	ASAP
Execute contract with pharmacy – Pilot started 7/1/15	7/1/15
Execute contract with Allscripts	7/17/15
Initiatives support 50% of planned target population capacity	7/15/15
Initiatives support 100% of planned target population capacity	9/1/15
First test report of required measures awaiting HPC specs	TBD
Enabling technology – Allscripts testing initiated training to be held in September	9/15
Enabling technology – Allscripts go-live 120 days after training	12/15-1/16
Palliative care trainings completed Will discuss when Palliative NP/PA hired	9/15/15
First patient seen	10/1/15

Community partners/subcontractors

Name	Business Address	Website	Contact Name	Contact Title	Contact Phone Number	Contact Email Address
Allscripts	8529 Six Forks Rd Raleigh, NC 27615	http://www.allscripts.com/	Jacob Efird	Sales Executive	919-2397461	Jacob.Efird@allscripts.com
Family Pharmacy	105 E. Main St. Milford, MA 01757	www.familypharmacyrx.com	Matthew Moen	VP of Clinical Services and Business Development	508-755-4173	matt@familypharmacyrx.com
Palliative Care Training	TBD					